PRINTED: 07/13/2011 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			UN	1B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155349	B. WING	-	06/22/2	2011
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R	1	ANDALLIA DRIVE		
SAINTA	NNE HOME			WAYNE, IN46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
K0000						
	A Life Safety C	Code Recertification	K0000			
	· ·	nsure Survey was				
		<u>-</u>				
	•	the Indiana State				
	Department of					
	accordance wi	th 42 CFR 483.70(a).				
	Survey Date: (06/22/11				
	Facility Number: 000240					
	Provider Numb	per: 155349				
	AIM Number:					
	/ Hor Hamber.	10027 1300				
	Survevor: Am	y Kelley, Life Safety				
	Code Specialis					
	Code Specians	•				
		fety Code survey,				
	Saint Anne Ho	me was found not in				
	compliance wi	th Requirements for				
	Participation ir	า				
	Medicare/Med	icaid, 42 CFR				
	· ·	O(a), Life Safety				
		2000 edition of				
	,	l Fire Protection				
	· ·	01, LSC (Life Safety				
	Code) and 410) IAC 16.2. The				
	original buildin	ng consisting of the				
	_	ilding and the main				
	entrance/dinir	-				
		Chapter 19 Existing				
	Health Care O	ccupancies.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21

Facility ID:

000240

TITLE

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 06/22/2	ETED
NAME OF I	PROVIDER OR SUPPLIEF	* }	•		DDRESS, CITY, STATE, ZIP CODE	•	
SAINT AI	NNE HOME		1900 RANDALLIA DRIVE FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	with a basement construction, to entrance/dining story fully spring Type V (111) or Rehabilitation of therapy gym is sprinklered but (000) constructions a fire alarm smoke detection and areas open The facility has and had a censulation of this surface of this surface of the surface of the facility was compliance with a forementione.	he story building ant of Type II (222) he main g room is a one anklered building of construction and the unit with a physical a one story fully ilding of Type V tion. The facility a system with on in the corridors a to the corridors. a capacity of 168 sus of 151 at the arvey. Robert Booher, REHS, Life list-Medical Surveyor on story found not in the the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21 Facility ID:

000240

If continuation sheet Page 2 of 12

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 01			(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	155349	A. BUII		<u></u>	06/22/2		
		1000+0	B. WIN		ADDRESS SITU STATE ZIR SODE	OOIZZIZ	011	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE			
SAINT AN	NNE HOME				WAYNE, IN46805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
K0044 SS=E	Horizontal exits, if with 7.2.4. 19.2.	used, are in accordance 2.5						
	Based on obser		K	0044	These door catch mechanisr	ns	07/15/2011	
	interview, the fa	acility failed to			will be repaired and added to inspection log sheets to ensu			
		ire door sets at the			that these doors continue to			
	·	idor entrance were			operate correctly.			
	_	comatically close						
		19.2.2.5 requires						
	horizontal exits							
	accordance with							
	· ·	res fire doors to be						
	_	automatic closing in						
	accordance with							
		80, Standard for						
	Fire Doors and							
	2–1.4.1 require							
		all be adjusted to						
		esistance of the						
	latch mechanis	•						
	_	eved on each door						
		s deficient practice						
	· ·	y residents in the						
	first and third f	loor lounges.						
	Findings includ	e:						
	Based on obser	vation with the						
	Director of Maii	ntenance on						
	06/22/11 at 12	2:39 p.m., the first						
	floor fire door s	set leading into the						
	apartment corri	idor did not latch						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21 Facility ID:

000240

If continuation sheet

Page 3 of 12

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155349			(X2) MULTIP A. BUILDING B. WING		01	(X3) DATE S COMPL 06/22/2	ETED
	ROVIDER OR SUPPLIER		19	00 RAI	DRESS, CITY, STATE, ZIP CODE NDALLIA DRIVE AYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K0046 SS=F	Maintenance or p.m., the third leading into the corridor did no frame. Based of the Director of time of observations were confirmed 3.1–19(b) Emergency lighting duration is provided 19.2.9.1. Based on observation in the confirmed of the confirmed on the confirmed of the confir	h the Director of 106/22/11 at 1:45 floor fire door set 2 apartment 2 to atch into the 3 an interview with Maintenance at the 3 atch in a doors 1 to be fire doors. I to be fire doors 1	K0046		The 1 1/2 hour duration inspection will be added to or emergency light inspection sheet. We will do this once a year starting with this test in month of July 2011. The mor of May monthly test paperwowas found and had been completed for May.	the nth	07/15/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21 Facility ID:

000240

If continuation sheet

Page 4 of 12

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 06/22/2	ETED
	PROVIDER OR SUPPLIER		-	1900 RA	DDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	test. Written reinspections and by the owner for authority having deficient praction occupants. Findings included Based on an observation of Maintenance and observations, the written records for the month of documentation regarding the based on an observation of Maintenance and observations, the month of the month	Il be fully the duration of the ecords of visual d tests shall be kept or inspection by the eg jurisdiction. This ice could affect all de: eservations with the intenance on in 12:30 p.m. to 1:45 ry operated its were observed e facility. Based on th the Director of the time of					

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			onstruction 01	(X3) DATE SURVEY COMPLETED	
		155349	A. BUII B. WIN		<u>-</u>	06/22/2	011
	PROVIDER OR SUPPLIER		<u> </u>	1900 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DRIVE WAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0064 SS=D	health care occupal 9.7.4.1. 19.3.5.6 Based on obser interview, the farensure 1 of 1 K extinguisher proceedings was in range. NFPA 10 Portable Fire Extended Chapter 4–3.20 periodic month ensure the presis in the operable is in the operable 4–3.3.1 require extinguisher with any condition lift operating instroam plate legist outward, (d) Sattamper indicated missing, (e) Full by weighing or Examination for damage, corrosclogged nozzle gauge reading of	acility failed to -Class portable fire essure gauge the acceptable 0, the Standard for ctinguishers, g) requires the ly check shall esure gauge reading ole range. NFPA 10, es any fire th a deficiency in sted in 4–3.2 (c) fuctions on ole and facing fety seals and fors not broken or lness determined hefting, (f) r obvious physical ion, leakage or and (g) Pressure or indicator in or position; shall	K	0064	We will replace this K class f extinguisher with a correctly unit. This unit was just put ir service with the June annual inspection and would have b caught with the July inspection	filled nto een	07/15/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21 Facility ID:

000240

If continuation sheet

Page 6 of 12

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 01	COMPLETED			
THIE TENIN	or condection	155349	A. BUILDING		06/22/2011			
		100010	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/22/2011			
NAME OF F	PROVIDER OR SUPPLIER		l	ANDALLIA DRIVE				
SAINT AI	NNE HOME		FORT WAYNE, IN46805					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)					
IAG		LSC IDENTIFYING INFORMATION)	TAG	BEIGENCT)	DATE			
	=	rocedures. This						
	deficient practi							
		rea but could affect						
	-	ff in the event of an						
	emergency.							
	Findings includ	e:						
	Based on an ob	servation with the						
	Director of Mai	ntenance on						
	06/22/11 at 1:	05 p.m., the gauge						
	on the K-Class							
	extinguisher in							
	_	xtinguisher was						
	overcharged. T							
	_	by the Director of						
	Maintenance at							
	observation.	the time of						
	3.1-19(b)							
K0000								
	A Life Safety Co	ode Recertification	K0000					
		sure Survey was						
	conducted by t	he Indiana State						
	Department of	Health in						
	accordance wit	h 42 CFR 483.70(a).						
	Survey Date: 0	6/22/11						
	· ·							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	03	COMPL	ETED
		155349	B. WIN			06/22/2011	
		I	D. WII.		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ANDALLIA DRIVE		
SAINT A	NNE HOME			1	VAYNE, IN46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Facility Numbe	r: 000240					
	Provider Numb	er: 155349					
	AIM Number:	100274960					
	Survevor: Amy	Kelley, Life Safety					
	Code Specialist						
	Code Specialis						
	A++b;c :fcC-f	oty Codo survey					
		ety Code survey,					
		ne was found not in					
	compliance with Requirements for						
	Participation in						
	Medicare/Medi	caid, 42 CFR					
	Subpart 483.70	O(a), Life Safety					
	from Fire, the 2	2000 edition of					
	· · · · · · · · · · · · · · · · · · ·	Fire Protection					
	,	01, LSC (Life Safety					
	'						
	1	IAC 16.2. The					
		unit and Therapy					
	'	eyed with Chapter					
	18 New Health	Care Occupancies.					
	The nursing ho	ome is a fully					
	sprinklered thr	ee story building					
	with a baseme	nt of Type II (222)					
	construction, t						
	· ·	g room is a one					
		nklered building of					
	' ' '						
		onstruction and the					
		unit with a physical					
		a one story fully					
	sprinklered bu	ilding of Type V					
	(000) construc	tion. The facility					
	has a fire alarn	n system with					
	l						

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349				(X3) DATE SURVEY COMPLETED 06/22/2011	
	PROVIDER OR SUPPLIER		19	900 RAI	DRESS, CITY, STATE, ZIP CODE NDALLIA DRIVE AYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0039 SS=E	and areas open. The facility has and had a cens time of this sur. The facility was compliance wit aforementioned requirements a following: Width of aisles or unobstructed) serv hospitals and nurs In limited care faci hospitals, width of least 6 feet. 18. Based on obser interview, the fensure the corr 2 corridors in thall was at least This deficient presidents on the Hall. Findings include Based on an obdirector of Mai 06/22/11 at 12	a found not in h the d regulatory s evidenced by the corridors (clear and ving as exit access in ing homes is at least 8 feet. lities and psychiatric aisles or corridors is at 2.3.3, 18.2.3.4 evation and acility failed to ridor width for 1 of the Rehabilitation at eight feet wide. Oractice affects all the Rehabilitation e: e:	K003	9	This aisle width deficiency wi addressed by an FSES to be conducted by RTM Consultar prior to the July 22nd comple requirement date.	nts	07/22/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21 Facility ID:

000240

If continuation sheet

Page 9 of 12

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

li li		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	A. BUIL	DING	NSTRUCTION 03	(X3) DATE S COMPL 06/22/2	ETED
		100010	B. WING		DDRESS, CITY, STATE, ZIP CODE	OOIZZIZ	
NAME OF I	PROVIDER OR SUPPLIER				ANDALLIA DRIVE		
SAINT AI	NNE HOME			FORT V	VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
K0046 SS=F	from suite E to Rehabilitation Is confirmed base with the Director at the time of the suite of t	suite O in the Hall. This was ed on an interview or of Maintenance he observation. g of at least 1½ hour ed in accordance with 7.9. Evation and acility failed to 0 emergency light east 1½ hour ested monthly and ordance with LSC Periodic Testing of nting Equipment tional test shall be every required d emergency at 30 day intervals of 30 seconds. An ell be conducted on battery powered ording system for not mour duration. El be fully the duration of the	КО	046	The 1 1/2 hour duration inspection will be added to or emergency light inspection sheet. We will do this once a year starting with this test in month of July 2011. The moof May monthly test paperwowas found and had been completed for May.	i the nth	07/15/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JDPD21 Facility ID:

000240

If continuation sheet

Page 10 of 12

NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, 1900 RANDALLIA DRIVE	
NAME OF PROVIDER OR SUPPLIER 1900 RANDALLIA DRIVE	
SAINT ANNE HOME FORT WAYNE, IN46805	
	N OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCE AT CROSS-REFERENCE AT CROSS-REFERENCE AT DEFICIE	TO THE APPROPRIATE
authority having jurisdiction. This	
deficient practice could affect all	
occupants.	
Findings include:	
Based on an observations with the	
Director of Maintenance on	
06/22/11 from 12:30 p.m. to 1:45	
p.m., ten battery operated	
emergency lights were observed	
throughout the facility. Based on an interview with the Director of	
Maintenance at the time of	
observation, there were no written	
records of a monthly test for the	
month of May 2011 and no	
documentation of an annual test	
regarding the battery operated	
emergency lights was available for review.	
Teview.	
3.1–19(b)	
K0033 SS=E Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	
Based on observation and K0033 This stairwell de	
	In FSES is to be
	22nd completion

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 04	(X3) DATE SURVEY COMPLETED 06/22/2011
	PROVIDER OR SUPPLIER	!	1900 R	ADDRESS, CITY, STATE, ZIP COD ANDALLIA DRIVE VAYNE, IN46805	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
	7.7.2. LSC 7.7 discharge to the exterior exit diallows no more exits to discharthe level of exit deficient praction residents, staff evacuated from third floors in the emergency. Findings includes Based on observation of Mai 06/22/11 at 12 southwest stair discharged onto not directly to building. This	the second and the event of an le: Evations with the ntenance on 2:30 p.m., the rand northeast stair to the first floor and the exterior of the was confirmed by Maintenance at the			